MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17046 17042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A 15 (a)
20 M 1766

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 739 Revolution St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Mae — Last: Ackinson

4. DATE OF DEATH: Month: December — Day: 19 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 17, 1903

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Fred Shanklin

14. MOTHER'S MAIDEN NAME: Ella Kidd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-12-0748

17. INFORMANT: Harry A. McKinson — Address: 739 Revolution, St. Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 da.
DUE TO (b): Nephrosclerosis. — 2 yrs
DUE TO (c): Diabetes mellitus — 7 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): A.S.C.V.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-5, 1967 to 12-19, 1967 that (I) (we) last saw the deceased alive on 12-19 1967, and that death occurred at 10:37 M, from causes and on the date stated above.

22a. SIGNATURE: John D. Yun — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): John P. Yun

22d. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 22, 1967

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cem.

23d. LOCATION (City or Town) (County) (State): Havre de Grace Harford Md.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17043 17043

1. **PLACE OF DEATH** a. COUNTY: Harford — Maisland MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN Ib: 60 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace, Md.
d. STREET ADDRESS: 809 S. Washington
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Charles Middle: E. Last: Baker

4. **DATE OF DEATH**: Month: 12/6 Day: 67 Year: 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/22/1876

9. AGE (If over 1 year last birthday): 91 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Plasterer

11. BIRTHPLACE (County & State, or foreign country): Rock Hall Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Baker

14. MOTHER'S MAIDEN NAME: Mary M Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Lindembe Taylor Address: 700 Lewis St., Havre de Grace, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac

4344

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Has had some enlargment of heart

DUE TO (c): Old infarcts

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/4/67, 19....., to 12/6/67, 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occurred at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: C Lewis MD M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Havre de Grace Md

23a. BURIAL CREMATION REMOVAL (Specify)

23b. DATE THEREOF: 12/9/67

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel

23d. LOCATION (City, town or county) (State): Rock Hall Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Thomas Pom

ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: DEC 11 1967

25b. REGISTRAR'S SIGNATURE: Wm Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20M 5-63

1

17043

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 1129 N. Bond Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Olivia — Middle: Mary — Last: Barrett

4. **DATE OF DEATH**: Month: 12 — Day: 26 — Year: 1967

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 2-28-1906

9. AGE (In years last birthday) yrs.: 61

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Franklin Richardson

14. MOTHER'S MAIDEN NAME: Harriett Legger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinomatosis
DUE TO
(b):
DUE TO
(c): Malignant Neoplasm of the Thyroid Gland
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
194X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): a) Hypertensive Cardiovascular disease b) Pneumonitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12 - 4, 1967 to 12-26 1967, that (I) (we) last saw the deceased alive on 12/26 1967, and that death occurred at 12:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/26/67

22c. PHYSICIAN'S NAME (Type): George T. Stansbury

22d. ADDRESS: 569 Revolution St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-31-67

23c. NAME OF CEMETERY OR CREMATORY: Berkley cem

23d. LOCATION (City or Town) (County) (State): Darlington Harford Md

24. FUNERAL DIRECTOR — ADDRESS: George W Tittle Bel Air Md

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: Edward Jones

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17049

CERTIFICATE OF DEATH

17045

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4M & 13 days

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Perryville 07,2
d. STREET ADDRESS: Rt - 222
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Citizens Nursing Home

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Townley — Lost: Benson

4. DATE OF DEATH: Month: Dec. — Doy: 1, — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Cau.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 2, 1873
9. AGE (In yeors last birthday) 94 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & Stote, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas J. Benson
14. MOTHER'S MAIDEN NAME: Damonis H. Barton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 218-18-3282A
17. INFORMANT — Address: Mrs. Clarence I. Benson, Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cerebral Sclerosis - — INTERVAL BETWEEN ONSET AND DEATH: 4 mos
DUE TO (b): Arteriosclerosis - — 8 yrs
DUE TO (c):
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost.
4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from July 9, 1967, to Nov. 30, 1967, that (I) (we) last saw the deceased alive on Nov 30 1967, and that death occurred at ____ M, from causes ond on the date stated abave.

22a. SIGNATURE: Clarence I. Benson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-1-67
22c. PHYSICIAN'S NAME (Type): Clarence I. Benson M.D.
22d. ADDRESS: Port Deposit, Maryland. 21904

23a. BURIAL, CREMATION, REMOVAL (Spesify): Burial
23b. DATE THEREOF: 12-5-1967
23c. NAME OF CEMETERY OR CREMATORY: Hopewell Cemetery
23d. LOCATION (City or Town) (County) (State): Port Deposit, Md.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son
ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: DEC 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17050

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

1. DECEASED-NAME (Type or print) First: Caroline	Middle:	Last: Beran	2a. DATE OF DEATH Month: 12 Day: 16 Year: 67 (17046)
2b. HOUR: 4 PM			
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH: 10-6-1883	6. AGE (In years last birthday): 84 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Harford County Md.
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Bream Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House-wife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Harford	13c. CITY OR TOWN: Havre de Grace	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: Union & Revolutions Sts.			
14. FATHER'S NAME First: Victor	Middle:	Last: Jackson	15. MOTHER'S MAIDEN NAME First: Mollie Middle:	Last: Crawford
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-05-4978	17. INFORMANT: John Beran Address: 101 Brooks Ave. Magnolia N.J.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cong. Heart Failure, due to
DUE TO, OR AS A CONSEQUENCE OF (b): generalized arteriosclerotic C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): Gangrene of foot, due to arterial occl.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION: 11-3-67	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: as above (c)	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 11-1, 1967, to 12-16, 1967, that (I) (we) last saw the deceased alive on 12-16 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry H. Kwak	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 12-18-67	
22d. PHYSICIAN'S NAME (Type): HENRY H. KWAK	22e. ADDRESS: 608 S. Union Ave. Havre de Grace Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 12/19/67	23c. NAME OF CEMETERY OR CREMATORY: Angel Hill	23d. LOCATION (City or Town) (County) (State): Havre de Grace, Md.
24. FUNERAL DIRECTOR: Lemuel Ben	ADDRESS: Havre de Grace Md.	25a. REC'D BY REGISTRAR DATE: DEC 26 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMI. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7059 1047

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR (RURAL)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 208 HILLENDALE Rd

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
d. STREET ADDRESS: Box 24, R.D. #2, MacPHAIL Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAX — Middle WILLIAM — Last BLEVINS
4. DATE OF DEATH: Month DEC — Day 5 — Year 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 26, 1923
9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: FUEL OIL
11. BIRTHPLACE (State or foreign country): DECATOR, NEBRASKA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William M. Blevins
14. MOTHER'S MAIDEN NAME: Alta Leona Craig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 215-18-8385
17. INFORMANT: Address: Mrs. Ellen Kabina, Box 24, R.D. 2, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): SUFFOCATION AND INTERNAL INJURIES
DUE TO (b): CHEST AND ABDOMEN -, MULTIPLE FRACTURES RIBS LEFT CHEST, PELVIS
DUE TO (c): FEMURS & COMPOUND OF RT. FEMUR
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: INSTANT

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): CRUSHED BETWEEN OIL TRUCK AND TREE TRUNK
20c. TIME OF INJURY Month, Day, Year: Hour 1:25 pm DEC 5 19 67
20d. INJURY OCCURRED While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME DRIVEWAY
20f. (City or town) BEL AIR (County) HARFORD (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Heuman M.D.
EXAMINER'S NAME (Type): PHILIP W. HEUMAN, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 307 HICKORY BEL AIR, Md
22. DATE SIGNED: Dec 5, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 8, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) Bel Air (County) Harford (State) Md

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a. RECD BY REGISTRAR — DATE: DEC 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2053 1048

1. PLACE OF DEATH — a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 113 N. Union Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: — Last: Borneman
4. DATE OF DEATH: Month: December — Day: 20 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: May 27 1887
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor Building
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustus Borneman
14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 219-10-6201
17. INFORMANT — Address: Helen G. Borneman Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO
(b): Arteriosclerotic Heart Disease — 10 days
DUE TO
(c): Pneumonia & pleurisy left lung — 12 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 6, 19 67 to Dec. 20, 19 67, that (I) (we) last saw the deceased alive on Dec. 20 19 67, and that death occurred at 1:15 M, from causes and on the date stated above.

22a. SIGNATURE: Edward J. Simon — M.D. — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐
22b. DATE SIGNED: 12-20-67
22c. PHYSICIAN'S NAME (Type): EDWARD J SIMON
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: DEC. 23 1967
23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEM.
23d. LOCATION (City or Town) (County) (State): HAVRE DE GRACE, MD

24. FUNERAL DIRECTOR — ADDRESS: R. Madison Mitchell, Havre de Grace, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17053 17049

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 103 Edmund Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RAYMOND — Middle: E. — Last: BUDNICK

4. DATE OF DEATH: Month: December — Day: 20, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 April 1905

9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taxi-cab Owner

10b. KIND OF BUSINESS OR INDUSTRY: Taxi-Cab

11. BIRTHPLACE (State or foreign country): Aberdeen, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick H. Budnick (D)

14. MOTHER'S MAIDEN NAME: Edna L. Walters (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: F. Hollis Budnick, Aberdeen, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Gunshot wound of head
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PROBABLY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Shot by unknown assailant

20c. TIME OF INJURY Hour: 9:30 p.m. Month, Day, Year: 12-20- 1967

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street

20f. (City or town) (County) (State): Havre de Grace Harford Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate, M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):

22. DATE SIGNED: December 21, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 23 Dec. 1967
23c. NAME OF CEMETERY OR CREMATORY: St Paul Lutheran Cemetery
23d. LOCATION (City or Town) (County) (State): Aberdeen (Harford) Md.

24. FUNERAL DIRECTOR: Tarring Funeral Home — ADDRESS: Aberdeen, Md. 21001

25a. RECD BY REGISTRAR DATE: DEC 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17654 17650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: RD#2, Box 1B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Camell — Last: Butcher

4. DATE OF DEATH: Month: 12 — Day: 23 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 6 1895

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY? U.

13. FATHER'S NAME: Thomas Butcher

14. MOTHER'S MAIDEN NAME: Mary V Yeaple

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Jonathan Butcher — Address: 4276 Main St Dallastown, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Urinary bladder obstruction & perforation — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Adenocarcinoma of prostate — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
I71X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia, Generalized peritonitis, Cystitis acute

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or Town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-23 1967 to 12/23, 1967 that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Richard J. Cook M.D — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 12/23/67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 27 1967

23c. NAME OF CEMETERY OR CREMATORY: Proctor Hill

23d. LOCATION (City or Town) (County) (State): York York, Pa.

24. FUNERAL DIRECTOR: C. Madison Mitchell — ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE:

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form ... Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17055 — 17055

1 DECEASED NAME (Type or Print) First / Middle / Last: Margaret A Cahill				2a DATE KNOWN OF DEATH ☒ / ESTIMATED ☐: Month December Day 11 Year 1967	2b HOUR: 3:35 P.M.
3 SEX: M	4 RACE: W	5 DATE OF BIRTH: Aug 26, 1910	6 AGE (In years last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	2c DATE PRONOUNCED DEAD: Month Dec Day 11 Year 1967	2d HOUR: 3:35 P.M.
7a BIRTHPLACE (State or foreign country): Penn.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Harford Md.		
10. CITY OR TOWN OF DEATH: Havre de Grace	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Harford Memorial	12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired): HOUSE WIFE	12b KIND OF BUSINESS OR INDUSTRY: Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: N.Y.	13b COUNTY: 358 HIRLEY AVE.	13c CITY OR TOWN: Staten Island	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 358 Shirley Ave.	
14 FATHER'S NAME First / Middle / Last: MICHAEL FODOR		15 MOTHER'S MAIDEN NAME First / Middle / Last: ELIZABETH NOGY			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO: NONE	17 INFORMANT: JAMES P. CAHILL	ADDRESS: 358 Shirley Ave. Staten Island N.Y.	

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 465x

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No / City or Town / County / State	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D.
EXAMINER'S NAME (Type): Gerald E Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED. CAL. EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): 13 [illegible] Ave. Md.

22b DATE SIGNED: 12-11-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE: DEC. 15, 1967	23c NAME OF CEMETERY OR CREMATORY: Ocean View Cem.	23d LOCATION (City or Town) (County) (State): STATEN, ISLAND N.Y.	
24 FUNERAL DIRECTOR: L. Madison Mitchell	ADDRESS: Havre de Grace Md.	25a REC'D BY REGISTRAR DATE: DEC 18 1967	25b REGISTRAR'S SIGNATURE: Charles Judge	

VR A1SME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7056 — 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 65 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residance before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 229 N. Union Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF (Type or print): First: Carl — Middle: Fritz — Last: Carlson
4. DATE OF DEATH — Month: 12 — Day: 17 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/30/1890
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (County & State, or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl Johann Carlson
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Mrs. Rozalya Carlson — Address: 229 N. Union Ave Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis - intra-abdominal — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): Carcinoma of Stomach — 1½ years.
DUE TO (c):
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Month, Day, Year — Hour — a.m. — p.m.
20d. INJURY OCCURRED — While at work ☐ — Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 12th 19 66 to Dec. 16th 19 67 that (I) (we) last saw the deceased alive on Dec. 16th 19 67 and that death occurred at 8:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/18/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/21/67
23c. NAME OF CEMETERY OR CREMATORY: Asbury
23d. LOCATION (City, town or county) (State): Near Pennsville Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington Bros. — ADDRESS: Havre de Grace Md.
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 5-63

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1765 — 1705.3

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Bel Air
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2006 Valley View Court

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Bel Air
d. STREET ADDRESS: 2006 Valley View Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Catherine — Middle: Gladys — Last: Clark

4 DATE OF DEATH: Month: December — Day: 22, — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 13,1894
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (County & State or foreign country): Owls Head, Maine
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank W. Ames
14. MOTHER'S MAIDEN NAME: Adella Philbrook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----
16. SOCIAL SECURITY NO.: 309-10-2597
17. INFORMANT: (Husband) 838-5058 Address: 2006 Valley View — Mr. Edward Harding Clark — Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CARDIO-RESP. FAILURE — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): ADVANCED HYPERTENSIVE CARDIOVAS. DIS. — 5YRS.
DUE TO (c): HYPERTENSION SEVERE — 10YRS +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE, 1957, to 21 DEC, 1967, that (I) (we) last saw the deceased alive on 21 DEC 1967, and that death occurred at 8:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: H. Proctor Sidwell — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Ded. 22, 1967
22c. PHYSICIAN'S NAME (Type): H. Proctor Sidwell, M.D.
22d. ADDRESS: 401 Franklin St., Bel Air, Md. 21014

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: Dec. 26, 1967
23c. NAME OF CEMETERY OR CREMATORY: Green Mount Crematory
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams, Bel Air, Maryland 21014
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

Joseph William Foster

10 1

17053 17054

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delta
d. STREET ADDRESS: Stateville Rd.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Chester — Middle: — Last: Cooper

4. DATE OF DEATH: Month: December — Day: 12 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 16, 1888

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Owner

10b. KIND OF BUSINESS OR INDUSTRY: Dairy

11. BIRTHPLACE (County & State, or foreign country): Whiteford, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sidney Cooper

14. MOTHER'S MAIDEN NAME: Mary A. Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 187-30-1236

17. INFORMANT: Lillian C. Cooper — Address: Delta, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Myocardial infarction, Extensive — 5 days
DUE TO (c): A. S. C. V. D. — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-7 19 67 to 12-12 19 67 that (I) (we) last saw the deceased alive on 12/12 19 67 and that death occurred at [illegible] M, from causes and on the date stated above.

22a. SIGNATURE: Edward C. Lee, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/12/67

22c. PHYSICIAN'S NAME (Type): Edward C. Lee, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Nebo

23d. LOCATION (City or Town) (County) (State): Delta York Pa.

24. FUNERAL DIRECTOR: John H. Harkins — ADDRESS: Delta, Pa.

25a. REC'D BY REGISTRAR DATE: DEC 15 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7059 — 1886

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 14 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 904 Erie St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Nelson — Last: Cranshaw
4. DATE OF DEATH: Month: December — Day: 28 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Nelson Cranshaw
14. MOTHER'S MAIDEN NAME: Katie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Inanition & hypotension & hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): Carcinoma of liver
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1561

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/15, 1967, to 12/28, 1967, that (I) (we) last saw the deceased alive on 12/28/67 19____, and that death occurred at 9:46 A.M., from causes and on the date stated above

22a SIGNATURE: A.W. Erigoleit — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 12/28/67
22c PHYSICIAN'S NAME (Type): A.W. ERIGOLEIT
22d ADDRESS: Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b DATE THEREOF: Jan. 8 '68
23c NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School
23d LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR — ADDRESS

25a REC'D BY REGISTRAR DATE: JAN 10 1968
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7060

CERTIFICATE OF DEATH

17055

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: 11/30/to12/6/67
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: Md. — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   d. STREET ADDRESS: 520 S. Stokes St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: ALFRED — Last: Curry

4. DATE OF DEATH: Month: 12 — Day: 6 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 2, 1914

9. AGE (In years last birthday): 53 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: UNEMPLOYED

11. BIRTHPLACE (County & State, or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE AMOS CURRY

14. MOTHER'S MAIDEN NAME: SARAH JANE MORRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-12-9493

17. INFORMANT: Mrs. MARY A. CURRY — Address: 352 GIRARD, ST HAVRE DE GRACE Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY.
   IMMEDIATE CAUSE (a): Cardio Pulmonary Failure
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Bronchial Asthma with Bronchiolitis and Non Specific Pulmonary Inf.
   DUE TO
   (c): Myocardial Decompensation
   INTERVAL BETWEEN ONSET AND DEATH:

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastroduodenitis with Hepatic Insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/16, 1960, to 12/6, 1967, that (I) (we) last saw the deceased alive on 12/5 1967, and that death occurred at 5:50A M, from causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 12/7/67

22c. PHYSICIAN'S NAME (Type): George T. Stansbury, M.D.

22d. ADDRESS: 569 Revolution Street Havre de Grace, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Dec. 9 1967

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cem.

23d. LOCATION (City or Town) (County) (State): HAVRE DE GRACE HARFORD MD

24. FUNERAL DIRECTOR. ADDRESS: R. Madison Mitchell, HAVRE DE GRACE, MD.

25a. REC'D BY REGISTRAR DATE: DEC 11 1967

25b. REGISTRAR'S SIGNATURE: Thomas Jones

4 1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7061

CERTIFICATE OF DEATH

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY: HARFORD MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if not tuition: Residence before admission) a. STATE: Maryland b. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de Grace c. LENGTH OF STAY IN 1b: 14 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): HARFORD Memorial Hospital	d. STREET ADDRESS: R.D. 343A R.D. 2 e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John Middle — Last Dimeo	4. DATE OF DEATH: Month Dec. Day 17 Year 1967							
5 SEX: MALE	6 COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 10-22-1882	9. AGE (In years last birthday): 85 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b KIND OF BUSINESS OR INDUSTRY: Invalid	11. BIRTHPLACE (County & State or foreign country): Italy	12 CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME: Carmen Dimeo	14 MOTHER'S MAIDEN NAME: ?							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16. SOCIAL SECURITY NO.: Unk	17. INFORMANT: Carmen Dimeo Address: R.D. 2 Box 343 A Aberdeen, Md.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO (b): Ca. of prostate — >1 year.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): A.S. Cl. D. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 3, 1967, to 12/17, 1967 that (I) (we) last saw the deceased alive on 12-17 1967, and that death occurred at 5:40 P.M. from causes and on the date stated above

22a. SIGNATURE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS.	22b. DATE SIGNED
Edward C. Loo, M.D.	M.D. ☒	☐	☐	12/17/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.	22d. ADDRESS: Havre de Grace, Md.			

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
	12/21/67	Saint Joseph	Havre de Grace Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph P. Harvey	Havre de Grace Md 21078	DATE DEC 26 1967	Thomas Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17062

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
d. STREET ADDRESS: Box 66 Rt 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

3. NAME OF DECEASED (Type or print): First: Charlotte Middle: Elizabeth Last: Dorsey
4. DATE OF DEATH: Month: 12 Day: 18 Year: 1967
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-29-1895
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months: 5 Days: 20
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Smith
14. MOTHER'S MAIDEN NAME: Charlotte Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 212-33-4863
17. INFORMANT: Mrs. Hanna J. Taylor Address: 224 N. Main Port Deposit, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Diabetic Acidosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Diabetes Mellitus
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): (a) Cystic Arteriosclerotic Cardiovascular disease (b) Pneumonitis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/15, 1967 to 12/18, 1967 that (I) (we) last saw the deceased alive on 12/18 1967, and that death occurred at 4:53 P.M., from causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 12/21/67
22c. PHYSICIAN'S NAME (Type): George T. Stansbury
22d. ADDRESS: 324 Revolution St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-23-67
23c. NAME OF CEMETERY OR CREMATORY: Berkley Cemetery
23d. LOCATION (City or Town) (County) (State): Darlington Harford Md

24. FUNERAL DIRECTOR: Elmer Bullock ADDRESS: Havre de Grace, Md
25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 30 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7663

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1058

1. PLACE OF DEATH a. COUNTY [illegible] MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE [illegible] b. COUNTY alti.ore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible] - Rural c. LENGTH OF STAY IN 1b: 1 day	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Perry Hall - Rural
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): none	d. STREET ADDRESS: Forge Road e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: GEORGE	Middle: -	Last: DORSEY	4. DATE OF DEATH	Month: DECEMBER	Day: 31	Year: 19[illegible]		
5. SEX: Male	6. COLOR OR RACE: Negro	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: June 30, 1892	9. AGE (In years last birthday): 75 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman	10b. KIND OF BUSINESS OR INDUSTRY: Railroad	11. BIRTHPLACE (State or foreign country): Lorely, Balto.Co., Md	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Dorsey		14. MOTHER'S MAIDEN NAME: Jane Sconion	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no	16. SOCIAL SECURITY NO: 705-09-7589	17. INFORMANT Address: Thomas Dorsey, Box 68, Abingdon, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic C V Disease — INTERVAL BETWEEN ONSET AND DEATH
I221
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C. Palmer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city town or county): Bel Air Md
22. DATE SIGNED: 1-2-68

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Jan. 5, 19[illegible]	23c. NAME OF CEMETERY OR CREMATORY: [illegible] sbury Methodist Cemetery	23d. LOCATION (City or Town): Lorely	(County) (State): [illegible] Md
24. FUNERAL DIRECTOR: Orvan [illegible]	ADDRESS: [illegible] Thomas & Son, Abingdon, Md.	25a. RECD BY REGISTRAR DATE: JAN 3 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17064 Item #9 Film #... 12/26/67 ph

CERTIFICATE OF DEATH

1059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 5923 Green Hill Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Milton Middle T. Last Eierman

4. DATE OF DEATH: Month 12 Day 12 Year 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr 3 1905

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months ... Days ...
IF UNDER 24 HRS: Hours ... Min. ...

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Driver

10b. KIND OF BUSINESS OR INDUSTRY: BAKERY

11. BIRTHPLACE (County & State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frederick A. Eierman

14. MOTHER'S MAIDEN NAME: Johanna Jehermia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-4511

17. INFORMANT: Address: Herbert Eierman

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): massive myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
(b): Bleeding gastric ulcer (massive) — [redacted] 12 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-27, 19 67 to 12-12 19 67 that (I) (we) last saw the deceased alive on ... 19 ..., and that death occurred at 10:30 A.M. from causes and on the date stated above.

22a. SIGNATURE: Henry H. Kwak M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-13-67

22c. PHYSICIAN'S NAME (Type): Henry H. Kwak, M. D.

22d. ADDRESS: 608 S. Union Ave, Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/16/67

23c. NAME OF CEMETERY OR CREMATORY: Bulle Cem.

23d. LOCATION (City or Town) (County) (State): Balto Md

24. FUNERAL DIRECTOR: O.L. Eierman — ADDRESS: 667 Hurl Rd

25a. REC'D BY REGISTRAR DATE: DEC 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7065

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN ME D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Md. — b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Colora — RURAL
d. STREET ADDRESS Box 7
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: Lyndell — Middle: Allen — Last: Ewing
4 DATE OF DEATH Month: December — Day: 6 — Year: 19 67

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9-20-1962
9 AGE (In years last birthday): 5 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Ewing
14 MOTHER'S MAIDEN NAME: Agnes Rakes

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: None
17 INFORMANT: Wm Ewing — Address: Colora, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Multiple Injuries, Internal — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 18) Hit by car
20c TIME OF INJURY Month, Day, Year: hour 430 pm — 12-6 19 67
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f (City or town) Colora (County) Cecil (State) Md.

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Lewis C Palmer M.D.
EXAMINER'S NAME (Type): Lewis C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bel Air, Md.
22. DATE SIGNED: 12-6-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 12-9-67
23c NAME OF CEMETERY OR CREMATORY: West Nottingham
23d LOCATION (City or Town) (County) (State): Colora Cecil Md.
24 FUNERAL DIRECTOR: C.M. Mullen
ADDRESS: Rising Sun Md.
25a REC'D BY REGISTRAR DATE: DEC 8 1967
25b REGISTRAR'S SIGNATURE: Charles Jugg

VR ATSME (5) 6M 1/67

.3065

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1067

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - White Hall
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 274 - Bradenbaugh Road.

2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - White Hall
d. STREET ADDRESS: Box 274 Bradenbaugh Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Rose — Middle: A. — Last: Fischer

4. DATE OF DEATH: Month: Dec. — Day: 3 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: March 10, 1889

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Czechoslovakia.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Dusek

14. MOTHER'S MAIDEN NAME: Julie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-7374

INFORMANT: Rose Bauer — Address: Box 274 Bradenbaugh Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): A. S. C. V. disease — INTERVAL BETWEEN ONSET AND DEATH:

4271

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACC DENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1965, to 12/2, 1967, that I last saw the deceased alive on 12/1, 1967, and that death occurred at 5 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. M. France M.D

ADDRESS (Street, city or town, state): Parkton MD

DATE SIGNED: 12/3/67

PHYSICIAN'S NAME (Type): A. M. France

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 6, 1967

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

22d. LOCATION (City, town, or county) (State): Belcamp, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Philip E. Vach — ADDRESS: 1211 Chesaco Ave

24a. REC'D BY REGISTRAR DATE: DEC 5 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgwood
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1802 Old Van Bibber Road

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b. COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgwood (rual)
d STREET ADDRESS: 1802 Old Van Bibber Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Fred. — Middle: — Last: Friskey
4 DATE OF DEATH: Month: 12 — Day: 29 — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: Cau
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 1-20-1885
9 AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b KIND OF BUSINESS OR INDUSTRY: Retired
11 BIRTHPLACE (County & State, or foreign country): Baltimore Co. Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: George F. Friskey
14 MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO:
17 INFORMANT: Frederick Friskey — Address: 21040 1802 Old Van Bibber Road

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Prostate C — INTERVAL BETWEEN ONSET AND DEATH
177X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Mets Bones.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-1, 19 65 to 12-29, 19 67, that (I) (we) last saw the deceased alive on 12-1 1967, and that death occurred at 10A M, from causes and on the date stated above.

22a SIGNATURE: Gerald E Palmer — MD ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 12-30-67
22c PHYSICIAN'S NAME (Type): Gerald E Palmer, M.D. — 22d. ADDRESS: Bel Air Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 1-2-1968
23c NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
23d LOCATION (City or Town) (County) (State): Baltimore Co. Md.

24 FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 7401 Belair Road (36)

25a. REC'D BY REGISTRAR — DATE: JAN 3 1968
25b REGISTRAR'S SIGNATURE: Charles Jones

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1668 — 706

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 Hours after death.

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1hr 12mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: Box 20
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Harold
4. DATE OF DEATH: Month: December — Day: 15 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 15 Dec 1967
9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min: 12 min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Havre de Grace, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert Harold
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Marvin King — Address: Post Rd. Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Immaturity — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Premature rupture of membranes
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 Dec, 1967, to 15 Dec, 1967, that (I) (we) last saw the deceased alive on 15 Dec 1967, and that death occurred at 11 M, from causes and on the date stated above.

22a. SIGNATURE: K. Nameen MD — M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 12/16/67
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill
23d. LOCATION (City or Town) (County) (State): Havre de Grace Md

24. FUNERAL DIRECTOR — ADDRESS: Jenny Funeral Home Havre de Grace Md.
25a. REC'D BY REGISTRAR — DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

7069 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1706

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 11/01 to 12/27/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizen's Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 842 Ostego
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert — Middle: M. — Last: Johnson

4. DATE OF DEATH: Month: December — Day: 27 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/11/1896

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Penna. R.R.

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph B. Johnson

14. MOTHER'S MAIDEN NAME: Mary Bryson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO: 717-07-6070

17. INFORMANT: Ruth V. Johnson — Address: Havre de Grace, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac Insufficiency
DUE TO (b): Arteriosclerosis - Cerebral Hemorrhage
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/6, 1967, to 12-27, 1967 that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at 11:20 AM, from causes and on the date stated above.

22a. SIGNATURE: A. L. Lewis M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-27-67

22c. PHYSICIAN'S NAME (Type): A. L. Lewis M.D.

22d. ADDRESS: 214 Union St., Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-30-67

23c. NAME OF CEMETERY OR CREMATORY: North East Methodist Cem.

23d. LOCATION (City or Town) (County) (State): North East, Maryland.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son

ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Frances Yingling

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17070

CERTIFICATE OF DEATH

17065

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace

c. LENGTH OF STAY IN ib: 11-11-67 to 12-31-67

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks, Maryland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Citizens Nursing Home

d. STREET ADDRESS: Rock Ridge Road

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Roberta	Jane	Johnson	Dec.	31	19 67

5 SEX	6. COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Colored	WIDOWED [X]	11-11-1881	86 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Home	Harford County Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jude Dorsey	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT Address
No	213-14-2211	Mrs. Edith Perry Rocks, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — 21141 — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): A.S.C.V.D. — 3 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.V.A. Generalized A.S.C.V.D., Senility

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
19			

21. **I certify** that (I) (this hospital) attended the deceased from 9/20/67, 19, to 12/31, 19 67 that (I) (we) last saw the deceased alive on 12/31, 19 67 and that death occurred at 7:30 A.M. from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS.	22b. DATE SIGNED
Dr. [illegible] Loo M.D.	ATTENDING PHYS. [X]	12/31/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Dr. [illegible] Loo	Havre de Grace, 211 N. Union Ave. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/3/1968	Chestnut Grove	Rocks, Harford, Maryland

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Kurtz Jarrettsville, Md.	JAN 3 1968	Charles Judge

21084

A3

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17071

CERTIFICATE OF DEATH

1 7 0 6 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY (In 1b): 38 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 451 Commerce Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ELANOR — Middle: S — Last: KNEIPP
4. DATE OF DEATH: Month: December — Day: 13 — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 21, 1905
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (County & State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry J. Smith
14. MOTHER'S MAIDEN NAME: Elizabeth Bear

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ———
16. SOCIAL SECURITY NO.: 180-07-1389
17. INFORMANT — Address: Charles J. Kneipp, Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): H.C.V.D. + A.S.C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO (b): Malignant Hypertension — years
DUE TO (c): ———
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Urinary Tract Infection

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-5, 1967, to 12-13, 1967, that (I) (we) last saw the deceased alive on 12-13 1967, and that death occurred at 1:30 AM, from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/13/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-15-1967
23c. NAME OF CEMETERY OR CREMATORY: Riverview Burial Park Cem.
23d LOCATION (City or Town) (County) (State): Lancaster Pa.

24. FUNERAL DIRECTOR: Lee H. Patterson & Son — ADDRESS: Perryville, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

.7072

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 200 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Harford.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington.
d. STREET ADDRESS: P.O. Box 67
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norma Middle: M. Last: Knight
4. DATE OF DEATH: Month: 12 Day: 19 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 30, 1933
9. AGE (In years last birthday): 34 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Norman Knight
14. MOTHER'S MAIDEN NAME: Edna Henderson.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 216-56-8544
17. INFORMANT: Mrs. Norman Knight, Md. Address: DARLINGTON,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 days
DUE TO (b): Mitral Stenosis & Rheumatic fever — 15 yrs
DUE TO (c): Dehydration and Electrolyte imbalance — 1 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
410 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-30-, 1967, to 12-19, 1967, that (I) (we) last saw the deceased alive on 12-19 1967, and that death occurred at 5:5 PM, from causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/20/67
22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD
22d. ADDRESS: Darlington Md. 21034

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Dec. 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: Rock Run
23d. LOCATION (City or Town) (County) (State): Havre de Grace, Md.

24. FUNERAL DIRECTOR: John B. Hawkins ADDRESS: Delta, Pa.
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1707 — 1706 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 659 Otsego St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lester — Middle: Ray — Last: Lindsay

4. DATE OF DEATH: Month: December — Day: 15 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 29 1893

9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Signal Lyst.

10b. KIND OF BUSINESS OR INDUSTRY: Penn. R.R. Road

11. BIRTHPLACE (County & State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marshall E. Lindsay

14. MOTHER'S MAIDEN NAME: Fannie Irene Nail

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 717-07-5294

17. INFORMANT: Mrs. Pearl E. Lindsay — Address: 659 Otsego St, Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Hypertension - Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 10, 19 67 to Dec 15, 19 67 that (I) (we) last saw the deceased alive on Dec 10 1967, and that death occurred at 4:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: A Reed MD — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-18-67

22c. PHYSICIAN'S NAME (Type): A.L. LEWIS M.D.

22d. ADDRESS: Havre de Grace Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: DEC. 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: St Paul Lutherian Cem.

23d. LOCATION (City or Town) (County) (State): Harford Co. Md.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: DEC 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 20c, f & 21 12-18-67 ams

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7074 Item #2a, b, c & d Fin. 3/6 12/22/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17063

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a COUNTY Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c LENGTH OF STAY IN 1b —
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE Md/ N.J. — b COUNTY Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Demarest
d STREET ADDRESS 20 Brookside Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: Margaret Middle: L. Last: Moore
4 DATE OF DEATH Month: December Day: 7 Year: 19 67
5 SEX F
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH March 19 1882
9 AGE (In years last birthday) 85 yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min. —
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10b KIND OF BUSINESS OR INDUSTRY —
11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Henry Long
14 MOTHER'S MAIDEN NAME Hester Fiantz
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No
16 SOCIAL SECURITY NO —
17 INFORMANT Address: Ross H McCardell Demarest N.J.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Fracture Femur — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c) —
104.7

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) Fell
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 7-1 19 67
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) Rising Sun (County) Cecil (State) Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Sec'y Act
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) Gerald E Palmer MD
Address (Street, city, town, or county)
22. DATE SIGNED 12-7-67

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 12-9-67
23c NAME OF CEMETERY OR CREMATORY Chestnut Ridge Cem
23d LOCATION (City or Town) Falls Rd (County) Balto Co. (State)
24 FUNERAL DIRECTOR Bergee Funeral Home ADDRESS 3631 Falls Rd
25a RECD BY REGISTRAR DATE DEC 11 1967
25b REGISTRAR'S SIGNATURE Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17075

CERTIFICATE OF DEATH

17070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 hrs & 5 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: P.O 398
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: — Last: Muller-Thym

4. DATE OF DEATH: Month: 12 — Day: 4 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 21, 1894

9. AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11 BIRTHPLACE (County & State, or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Harry F. Toy

14. MOTHER'S MAIDEN NAME: Emma Clough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 182-07-5222-B

17. INFORMANT — Address: Harold Muller-Thym, Perryville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): A.S.C.V.D — 3 yrs
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o m. p m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to 12-4, 19 67, that (I) (we) last saw the deceased alive on 12-4 1967, and that death occurred at 3:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: John D. Yun — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 12-4-67

22c PHYSICIAN'S NAME (Type): JOHN D. YUN

22d ADDRESS: HAVRE DE GRACE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b DATE THEREOF: 12/7/1967

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Crematory

23d LOCATION (City or Town) (County) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR: Webster Macomber Jr. — ADDRESS: Tarring Funeral Home, Aberdeen, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 7 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1071

1 PLACE OF DEATH
a COUNTY Harford MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Osborne's RR Crossing

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a STATE Maryland
b COUNTY Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine
d STREET ADDRESS Route #2
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First [redacted] Middle HOBBS Last MULLINIX
4 DATE OF DEATH Month December Day 25 Year 1967

5 SEX Male
6 COLOR OR RACE W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 1/4/19
9 AGE (In years last birthday) 48 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b KIND OF BUSINESS OR INDUSTRY Farm Operation
11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Harrison Mullinix
14 MOTHER'S MAIDEN NAME Edna Hobbs

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ---
16 SOCIAL SECURITY NO 219-20-1789
17 INFORMANT Mr. Gene Mullinix, same as #9 Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Open Fracture Skull
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Train hit car
20c TIME OF INJURY Month, Day, Year Hour 6 pm 12-25 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Osborne's RR x
20f (City or town) Aberdeen (County) Ha (State) Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Ronald E Palmer M.D
EXAMINER'S NAME (Type) Ronald E Palmer MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) Bel Air, Md.
22. DATE SIGNED 12-25-67

23a BURIAL, CREMATION, REMOVAL (Specify) B
23b DATE THEREOF 12-29-1967
23c NAME OF CEMETERY OR CREMATORY Oak Grove
23d LOCATION (City or Town) Howard Co. (County) Md. (State)

24 FUNERAL DIRECTOR C.H. Waltz ADDRESS Box 211, Jarrettsville, Md.
25a REC'D BY REGISTRAR DATE DEC 29 1967
25b REGISTRAR'S SIGNATURE [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible] Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
6M 1 67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AT5ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

707 — 1707

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Osborne's RR Crossing

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
d. STREET ADDRESS: Route 4 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: SARAH — Middle: E. — Last: MULLINIX

4 DATE OF DEATH: Month: December — Day: 25 — Year: 1967

5 SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Female	W		9-21-16	51 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
housewife	home	Maryland	U.S.A.

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Alex Powell	Sadie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	215-07-5828	Mr. Gene Mullinix, same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Open Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
8104

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
X	Train hit car

20c TIME OF INJURY Month Day Year Hour a.m. p.m.	20d INJURY OCCURRED White at work ☐ Not White at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
12-25 1967 6		Osborne's RR X	Aberdeen Ha. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald E Palmer M.D
Address (Street, city, town, or county)
22. DATE SIGNED: 12-26-67

23a. BURIAL CREMATION REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	12-29-1967	Oak Grove	Howard Co., Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C.L. Waltz, Box 241, Sykesville, Md.	DEC 29 1967	Columbus Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATSME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT 40

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a STATE Md
b COUNTY Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d STREET ADDRESS Rt 40
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Ligouri Middle: A. Last: Nevins Jr.

4. DATE OF DEATH Month: December Day: 4 Year: 19 67

5 SEX: M

6. COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 6/27/1920

9 AGE (In years last birthday): 47 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b KIND OF BUSINESS OR INDUSTRY: Disabled Vet.

11 BIRTHPLACE (State or foreign country): Avoca Pa.

12 CITIZEN OF WHAT COUNTRY? U.S.A

13 FATHER'S NAME: Ligouri A. Nevins Sr.

14 MOTHER'S MAIDEN NAME: Katherine Sheehan

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes give war or dates of service): W W 2

16 SOCIAL SECURITY NO: Unk.

17 INFORMANT: Nancy Johns Nevins Address: RR 40 - Box 47 Havre de Grace Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald E Palmer M.D

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) Gerald E Palmer M.D. Address (Street, city, town or county)

22. DATE SIGNED 12-5-67

23a BURIAL, CREMATION, REMOVAL (Specify)

23b DATE THEREOF 12/6/67

23c NAME OF CEMETERY OR CREMATORY Mt Lebanon

23d LOCATION (City or Town) Lebanon (County) Pa. (State)

24 FUNERAL DIRECTOR Purington & Son Address Havre de Grace Md

25a RECEIVED BY REGISTRAR DEC 5 1967

25b REGISTRAR'S SIGNATURE J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7079

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 V41
20 M 1/68

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 22 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: C-1-5 Pritchard Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Alonza — Middle: Jackson — Last: Osborn

4. DATE OF DEATH: Month: December — Day: 18 — Year: 19 67

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 17 Nov. 1893
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter-Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Building Contracting
11. BIRTHPLACE (County & State, or foreign country): Aberdeen, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Osborn
14. MOTHER'S MAIDEN NAME: Ethel M. Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 218-10-8365--A
17. INFORMANT: Wife, Address: Same as 2 C & D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombotic occlusion ant desc Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Arteriosclerotic heart disease — 16 yrs
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary hemorrhage, right
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/18, 1967, to 12/18, 1967, that (I) (we) last saw the deceased alive on Dec. 18 1967, and that death occurred at 11:20 AM, from causes and on the date stated above.

22a. SIGNATURE: Richard J. Colfer M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/18/67
22c. PHYSICIAN'S NAME (Type): Richard J. Colfer, M.D.
22d. ADDRESS: Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 21 Dec. 1967
23c. NAME OF CEMETERY OR CREMATORY: Bakers Cemetery
23d. LOCATION (City or Town) (County) (State): Aberdeen, (Harford) Maryland

24. FUNERAL DIRECTOR: Tarring Funeral Home
ADDRESS: Aberdeen, Md. 21001
25a. REC'D BY REGISTRAR DATE: DEC 21 1967
25b. REGISTRAR'S SIGNATURE: Marie Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence, before admission) — a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 212 S. Rogers St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lena — Middle: Virginia — Last: Papalia
4. DATE OF DEATH: Month: December — Day: 20 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 20, 1916
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant owner
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State, or foreign country): Mouth of Wilson, Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Vaught
14. MOTHER'S MAIDEN NAME: Ida Rutherford (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: Husband--Same as 2 C & D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Metastatic Carcinomatosis, Abdominal — INTERVAL BETWEEN ONSET AND DEATH: 4 wks.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Adenocarcinoma of ovary — INTERVAL BETWEEN ONSET AND DEATH: 4 mo.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/15, 1967 to 12/20, 1967, that (I) (we) last saw the deceased alive on 12/20 1967 and that death occurred at 3:55 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 12-26-67
22c. PHYSICIAN'S NAME (Type): Peter P. Rodriguez M.D.
22d. ADDRESS: 28 W. St. Aberdeen Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 23 Dec. 1967
23c. NAME OF CEMETERY OR CREMATORY: Baker Cemetery
23d. LOCATION (City or Town) (County) (State): Aberdeen (Harford) Maryland

24. FUNERAL DIRECTOR — ADDRESS: Tarring Funeral Home, Aberdeen, Md. 21001
25a. REC'D BY REGISTRAR DATE: DEC 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7081 — 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (a)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Bel Air
d. STREET ADDRESS: Conowingo Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beulah — Middle: Jane — Last: Poplin
4. DATE OF DEATH: Month: December — Day: 18, — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 29,1904
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (County & State, or foreign country): Sparta, North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert L. Choate
14. MOTHER'S MAIDEN NAME: Vena Jane Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----
16. SOCIAL SECURITY NO: 219-16-3637
17. INFORMANT (Husband) 838-6664 Address: P.O.Box#244
Mr. J. Quincy Poplin — Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure terminating — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
DUE TO (b): Chronic A.S.C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple sclerosis 1941; Radical mastectomy ca. left breast.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): 11/15/67
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1941, 19__, to Dec. 18, 1967 that (I) (we) last saw the deceased alive on Dec. 17, 1967, and that death occurred at 6:a M, from causes and on the date stated above.

22a. SIGNATURE: Willard P. Hudson, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Dec.18,1967
22c. PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.
22d. ADDRESS: Forest Hill, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec.20,1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co., Md. 21014

24. FUNERAL DIRECTOR: Joseph William Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25a. REC'D BY REGISTRAR DATE: DEC 20 1967
25b. REGISTRAR'S SIGNATURE: M. Charles Jagoe

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1707

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 9 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
d. STREET ADDRESS: Castleton Rd.
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Emmett — Middle: Van — Last: Reeves

4. DATE OF DEATH: Month: 12 — Day: 28 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4 July 1882

9. AGE (In years last birthday): ~~82~~ 85 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Melvin Vance Reeves

14. MOTHER'S MAIDEN NAME: Millie Dalton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO: 220-50-1838

17. INFORMANT: Holice Dawson — Address: Fallston, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pneumonia and Bronchitis — INTERVAL BETWEEN ONSET AND DEATH: 36 hours
DUE TO (b): Arteriosclerosis — 10 yrs
DUE TO (c): old Age
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 493 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-28, 1967 to 12-28, 19__, that (I) (we) last saw the deceased alive on 12-28 1967, and that death occurred at 4:17 P.M. from causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 12/29/67

22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD

22d. ADDRESS: Darlington, Md 21034

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 31 Dec. 67

23c. NAME OF CEMETERY OR CREMATORY: Franklin Bapt. Cemetery

23d. LOCATION (City or Town) (County) (State): Darlington, Maryland

24. FUNERAL DIRECTOR: Norman G. Jarrett

ADDRESS: Jarrett Funeral Home, Aberdeen, Md. 21001

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1708?

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1707a

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Box 325
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Paul — Middle: A — Last: Reynolds

4 DATE OF DEATH: Month: December — Day: 20 — Year: 67

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Aug. 6 1938

9 AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: Gas Station

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Wallace W. Reynolds

14 MOTHER'S MAIDEN NAME: Esther Ida Cosmer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO: 214-36-9804

17 INFORMANT — Address: Howard L. Baker, Elkton, Md.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Fracture of Skull
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 8254

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Auto Accident

20c TIME OF INJURY Month Day Year Hour a.m. p.m.: 730 — 12 - 20 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home farm, factory, street office bldg., etc.): Rt. 7

20f (City or town) (County) (State): Perryville Cecil Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D.

EXAMINER'S NAME (Type): Gerald E Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): Bel Air, Md.

22. DATE SIGNED: 12-20-67

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 12-23-67

23c NAME OF CEMETERY OR CREMATORY: North East Methodist Cem.

23d LOCATION (City or Town) (County) (State): North East Maryland.

24 FUNERAL DIRECTOR: Lee A. Patterson & Son

ADDRESS: Lee A. Patterson & Son, Perryville, Maryland,

25a RECD BY REGISTRAR DATE: DEC 28 1967

25b REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1084 — 7079

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: MARYLAND 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 607 Maple View Drive

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 607 Maple View Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First illiam Middle Lee Last Robinson

4. DATE OF DEATH: Month Dec Day 26 Year 1967

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 4,1892

9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Harford County Highway Dept.

11. BIRTHPLACE (State or foreign country): Rutledge, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Evans Robinson

14. MOTHER'S MAIDEN NAME: Alverta Coe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service): 214-22-7471

17. INFORMANT: 607 Maple View Drive Mrs. Henrietta Robinson (Wife) Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio Sclerotic Cardio Vascular Disease
4221
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. No

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE — Philip W. Heuman

EXAMINER'S NAME (Type): aPhilip W. Heuman, M.D.

CHIEF MEDICAL EXAMINER ☐
M D ASSISTANT MED.CAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Dec 26, 1967

Address (Street, city, town or county): Bel Air, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/29/1967

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Mem. Gardens

22d. LOCATION (City, town, or country) (State): Bel Air, Harford, Maryland

23. FUNERAL DIRECTOR / ADDRESS: Charles E. Kurtz Jarrettsville, Md.

24a. REC'D BY REGISTRAR DATE: DEC 28 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

21084

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 4 should be forwarded to the Chief Medical Examiner's Office at a later date. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

.7085. 170 0

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen.
d. STREET ADDRESS: R.D#1 Box 389
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Frederick Middle William Last Siebert
4. DATE OF DEATH: Month 12 Day 15 Year 1967
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 15 Dec. 1887
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Herman Rhinehart Siebert
14. MOTHER'S MAIDEN NAME: Lorentine Mench.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.: 218-14-8204
17. INFORMANT: Address: Mrs. E. Siebert. Same as this.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6-8 hrs
DUE TO
(b): Arteriosclerosis and — 3 yrs
DUE TO
(c): Diabetes — 5 yrs
7201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-13, 1967 to 12-15, 1967 that (I) (we) last saw the deceased alive on 12-13 1967, and that death occurred at 8:22 P.M., from causes and on the date stated above

22a. SIGNATURE: Dudley Phillys M.D. ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12/16/67
22c. PHYSICIAN'S NAME (Type): Dudley Phillys
22d. ADDRESS: Darlington, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 22 Dec, 1967
23c. NAME OF CEMETERY OR CREMATORY: Calvary Methodist Cemetery
23d. LOCATION (City or Town) (County) (State): Churchville, Maryland

24. FUNERAL DIRECTOR: Tarring Funeral Home
ADDRESS: Aberdeen, Md. 21001
25a. REC'D BY REGISTRAR DATE: DEC 20 1967
25b. REGISTRAR'S SIGNATURE: Timothy Juggins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7085 7085

1 PLACE OF DEATH
a. COUNTY Harford MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington
c LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington
d. STREET ADDRESS 121
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First NATHAN Middle D. Last SMITH JR.

4. DATE OF DEATH Month 19 Dec 67 Day Year 19

5. SEX Male

6. COLOR OR RACE White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 2 Nov 1905

9 AGE (In years last birthday) 62 yrs

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument Repairman

10b KIND OF BUSINESS OR INDUSTRY APG., Md.-U.S. Govt.

11 BIRTHPLACE (County & State or foreign country) Jackson, Tenn

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nathan D.Smith SR. (D)

14. MOTHER'S MAIDEN NAME Rose Belle Hankenson (D)

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWII

16 SOCIAL SECURITY NO. 147-09-5683

17. INFORMANT Address Wife-- Ruth Smith, Darlington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute Massive Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Atherosclerosis
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH
IMMED. 24 HRS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 10, 1963, to Dec 19, 1967, that (I) (we) last saw the deceased alive on Dec 19 1967, and that death occurred at 2P. M, from causes and on the date stated above.

22a SIGNATURE Dudley Phillips M.D ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 12/19/67

22c. PHYSICIAN'S NAME (Type) Dudley Phillips MD

22e. ADDRESS DARLINGTON MD 21034

23a BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 21 Dec 67

23c NAME OF CEMETERY OR CREMATORY Smiths Chapel Cemetery

23d LOCATION (City or Town) (County) (State) Churchville, Maryland

24 FUNERAL DIRECTOR Kenneth B. Largo

ADDRESS Tarring Funeral Home Aberdeen, Maryland 21001

25a RECD BY REGISTRAR DATE DEC 26 1967

25b REGISTRAR'S SIGNATURE Juliette Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 ___ 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17087 17087

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Darlington
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Smith Road (Box #149)

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Darlington
d. STREET ADDRESS: Smith Road (Box #149)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: James — Last: Sullivan
4 DATE OF DEATH: Month: December — Day: 19, — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: July 20, 1918
9 AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b KIND OF BUSINESS OR INDUSTRY: Life Insurance
11 BIRTHPLACE (State or foreign country): Pittsburgh, Pennsylvania
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: William Sullivan
14 MOTHER'S MAIDEN NAME: Anna Amelia Flannigan

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): Yes (If yes, give war or dates of service): W.W. #2
16 SOCIAL SECURITY NO: 210-05-4944
17 INFORMANT: (Wife) 939-3385 Mrs. Betty M. Sullivan — Address: 322 South Union Ave. Havre de Grace, Md. 21078

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): ACUTE ALCOHOLISM, MALNUTRITION — INTERVAL BETWEEN ONSET AND DEATH: 4 wks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH: No
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d INJURY OCCURRED White at work ☐ Not White at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Heuman M.D.
EXAMINER'S NAME (Type): Philip W. Heuman, M.D.
Address (Street, city, town or county): 307 Hickory Ave., Bel Air, Md. 21014
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐
22. DATE SIGNED: Dec. 19, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Dec. 21, 1967
23c NAME OF CEMETERY OR CREMATORY: St. Ignatius Church Cem.
23d LOCATION (City or Town) (County) (State): Hickory, Harford Co., Md.

24 FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25a REC'D BY REGISTRAR DATE: DEC 26 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

Items 18, 19&21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH
12-18-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1308

1108

1 PLACE OF DEATH
a COUNTY Harford MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 300 Bourbon St

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE Md b COUNTY Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d STREET ADDRESS 300 Bourbon St
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First: John Middle: F Last: Sutor Jr
4 DATE OF DEATH Month: December Day: 4 Year: 19 67
5 SEX M
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH MAR. 23, 1909
9 AGE (In years last birthday) 58 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER
10b KIND OF BUSINESS OR INDUSTRY UNEMPLOYED
11 BIRTHPLACE (State or foreign country) HAVRE DE GRACE, MD
12 CITIZEN OF WHAT COUNTRY U.S.A.

13 FATHER'S NAME JOHN F. SUTOR, SR.
14 MOTHER'S MAIDEN NAME EDITH M. SUTOR

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —
(If yes give war or dates of service)
16 SOCIAL SECURITY NO 213-16-4664
17 INFORMANT Mrs. Emma J Alvey Address 6401 Highland AVE Balto. Md. 21206

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Alcoholis, acute and chroni
DUE TO
(b) Fatty degeneration Liver
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
41.1
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE Gerald C Palmer MD
EXAMINER'S NAME (Type) Gerald C Palmer MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐ Bel Air Md
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED 12-4-67

23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b DATE THEREOF 12-7-1967
23c NAME OF CEMETERY OR CREMATORY Angel Hill Cem.
23d LOCATION (City or Town) (County) (State) Havre de Grace Harford Md.

24 FUNERAL DIRECTOR ADDRESS L. Madison Mitchell, Havre de Grace, Md.
25a. REC'D BY REGISTRAR DEC 8 1967
25b REGISTRAR'S SIGNATURE J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(G) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17089

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIRK ARMY HOSPITAL, ABERDEEN PG, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
d. STREET ADDRESS: 670 West Bel Air Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HUGH — Middle: COURTNEY — Last: SUTTLE

4. DATE OF DEATH: Month: DEC — Day: 27 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 NOV 1910

9. AGE (In years last birthday): 57 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (County & State, or foreign country): Perry Co, Perryville, Ala

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES B. SUTTLES

14. MOTHER'S MAIDEN NAME: DELLA BYRD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes give war or dates of service) 11 May 1942

16. SOCIAL SECURITY NO: 420-20-5825

17. INFORMANT: Dorothy Suttle, 670 West Bel Air Ave — Address: Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Gunshot Wound of Neck — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
E19.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES XX NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Removing weapon from automobile

20c. TIME OF INJURY Month, Day, Year, Hour a.m./p.m.: 1130 XXX Dec 27 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Aberdeen (County) Harford (State) Maryland

21. I certify that (I) (~~this doctor~~) attended the deceased from 27 Dec 67, 1967, to 27 Dec ___, 1967, that (I) (not) last saw the deceased alive on 27 Dec 67 19___, and that death occurred at 1130A M, from causes and on the date stated above.

22a. SIGNATURE: William W. Babson Jr. — M.D. ATTENDING PHYS XX MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 27 Dec 67

22c. PHYSICIAN'S NAME (Type): WILLIAM W. BABSON, CPT, MC

22d. ADDRESS: KIRK ARMY HOSPITAL, ABERDEEN PG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 2, 1968

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION (City or Town) Arlington, (County) (State) Va.

24. FUNERAL DIRECTOR: [illegible] — ADDRESS: [illegible] Md

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1080 Item #9 Fi... 1,085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 **PLACE OF DEATH** a. COUNTY: Harford — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — STATE: Maryland — c. LENGTH OF STAY IN this place: 7 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bevin Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — b. COUNTY: Harford — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: Bevin Nursing Home — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARGEURITE — Middle: — Last: TAYLOR

4. **DATE OF DEATH**: Month: 12 — Day: 8 — Year: 67 — 19

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 6/22/1904 — 9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife — 10b. KIND OF BUSINESS OR INDUSTRY: — — 11. BIRTHPLACE (County & State or foreign country): Newton, Kansas — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Steele — 14. MOTHER'S MAIDEN NAME: Elizabeth Winton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: unk. — 17. INFORMANT: Zachary W. Taylor — Address: 212 A. Lafayette Circle, Mrs. Hughes, Philadelphia, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypostatic pneumonia

DUE TO (b): arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carbonic tumor type. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19....., to ....., 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occurred at ..M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 12/8/67

22c. PHYSICIAN'S NAME (Type): LAJOS I. MEZEI, M.D. — 22d. ADDRESS:

23a. BURIAL CREMATION, REMOVAL (Specify): — 23b. DATE THEREOF: 12/11/67 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort — 23d. LOCATION (City, town or county) (State): Alexandria Va.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hamilton & Son, Havre de Grace, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 13 1967 — 25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
20M 5-63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carbon papers, if any) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7691

CERTIFICATE OF DEATH

1036

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN PROVING GROUND
c. LENGTH OF STAY IN 1b: 1 hr 5 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIRK ARMY HOSPITAL, ABERDEEN PG, MD.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN PROVING GROUND
d. STREET ADDRESS: 2756 C AUGUSTA STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First TRACEY — Middle LAMOENT — Last TAYLOR

4. DATE OF DEATH: Month DEC — Day 18 — Year 1967

5. SEX: MALE
6. COLOR OR RACE: NEG
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 18 DEC 67
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours 1 — Min 5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (County & State, or foreign country): HARFORD CO, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FAIRLY W. TAYLOR
14. MOTHER'S MAIDEN NAME: BRENDA JAGOE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: N/A
17. INFORMANT Address: BRENDA TAYLOR, 2756 C AUGUSTA ST, APG, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH
776x
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(the hospital)~~ attended the deceased from 18 DEC, 1967, to 18 DEC, 1967 that (I) ~~(we)~~ last saw the deceased alive on 18 DEC 1967, and that death occurred at 1045 AM, from causes and on the date stated above

22a. SIGNATURE: Richard H Heller Cpt, mc — MD — ATTENDING PHYS ☐ — MED DIRECTOR ☐ — STAFF PHYS ☒
22b. DATE SIGNED: 18 DEC 67
22c. PHYSICIAN'S NAME (Type): RICHARD H. HELLER, CPT, MC
22d. ADDRESS: KIRK ARMY HOSP, ABERDEEN PG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-21-67
23c. NAME OF CEMETERY OR CREMATORY: Raleigh National Cemetery
23d. LOCATION (City or Town) (County) (State): Raleigh North Carolina

24. FUNERAL DIRECTOR: Bullock's Mortuary
ADDRESS: 556 Lewis St. Aberdeen, Md
25a. RECD. BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE:

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ____ Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7092

1. PLACE OF DEATH — a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): KIRK ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 4 Star Trailer Camp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

25

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
SHERRY	N.	VANCE	December	7,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Female	White	NEVER MARRIED ☒	21 July 1967		4	15		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	Infant	APG., Maryland	U.S.A.

13. FATHER'S NAME: Kenneth P. Vance
14. MOTHER'S MAIDEN NAME: Drucilla S. Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
N/A	N/A	Father, Same as 2 C & D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute otitis media (SDII)
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street city, town, or county)
22. DATE SIGNED: December 7, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11 Dec. 67	Baltimore National Cemetery,	Baltimore, Maryland

24. FUNERAL DIRECTOR	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tarring Funeral Home, Aberdeen, Maryland	DEC 11 1967	Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7693

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 423 Webb Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dora — Middle: Edith — Last: Webb

4. DATE OF DEATH: Month: 12 — Day: 11 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 30 June 1901

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY: Bata Shoe Company

11. BIRTHPLACE (County & State or foreign country): Russell County, Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Elbert Fuller

14. MOTHER'S MAIDEN NAME: Caldonia Compton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Frank S. Webb, Havre de Grace, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): A.S.C.V.D. — ? years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4331

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus + peripheral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-28-67, 19__, to 12-11, 1967, that (I) (we) last saw the deceased alive on 12/11/1967 and that death occurred at 3:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: 12/14/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 14 Dec. 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City or Town) (County) (State): Bel Air (Harford) Maryland

24. FUNERAL DIRECTOR: Webster Macomber Sr. — ADDRESS: Tarring Funeral Home, Aberdeen, Md. 21001

25a. REC'D BY REGISTRAR: DEC 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health; prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

7094 — 7089

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun — Rural
d. STREET ADDRESS: R. F. D. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Malva — Middle: Bird — Last: Weir

4. DATE OF DEATH: Month: 12 — Day: 26 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 9--12--1898

9. AGE (In years last birthday): 69 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Cecil Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wilmer Curtis Bird

14. MOTHER'S MAIDEN NAME: Bella Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT Address: Mr. Harry Weir Sr. Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO (b): Arteriosclerosis & diabetes — 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour, a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-5, 1967, to 12-26, 1967, that (I) (we) last saw the deceased alive on 12-26 1967, and that death occurred at 7:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Neil R Taylor M.D — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: 12-28-67

22c. PHYSICIAN'S NAME (Type): Neil R. Taylor M.D.

22d. ADDRESS: Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-29-67

23c. NAME OF CEMETERY OR CREMATORY: Oxford Cem.

23d. LOCATION (City or Town) (County) (State): Oxford Pa.

24. FUNERAL DIRECTOR: Vernon E. Mueller — ADDRESS: Rising Sun, Md.

25a. RECD BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17095 17090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Hall
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Norrisville Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Hall RD #1 Box 55
d. STREET ADDRESS: Norrisville Road 12 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ALBERTA — Last: WILEY
4. DATE OF DEATH: Month: Dec. — Day: 26 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/22/1882
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Harford Creamery, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew L. Anderson
14. MOTHER'S MAIDEN NAME: Luella Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: 220-44-2923
17. INFORMANT: Mrs. Frances A. Luckey
Address: RD 1 Box 55 White Hall, Md. 21161

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): A. S. C. V. disease
DUE TO
(c):
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__ to 12/26, 1967, that (I) (we) last saw the deceased alive on 12/25 1967, and that death occurred at 2 35 PM, from causes and on the date stated above.

22a. SIGNATURE: A. M. France M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/26/67
22c. PHYSICIAN'S NAME (Type): A. M. FRANCE
22d. ADDRESS: PARKTON, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/28/1967
23c. NAME OF CEMETERY OR CREMATORY: Bethel
23d. LOCATION (City or Town) (County) (State): Madonna, Harford, Md.

24. FUNERAL DIRECTOR — ADDRESS: Charles E. Kurtz Jarrettsville, Md.
25a. REC'D BY REGISTRAR DATE: DEC 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

21084

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17096

CERTIFICATE OF DEATH

17091

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Jarrettsville — 12-1
d. STREET ADDRESS: Box 27 Schuster Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clinton — Middle: Page — Last: Wimmer

4. DATE OF DEATH: Month: December — Day: 16 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/24/1914

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assessor

10b. KIND OF BUSINESS OR INDUSTRY: Tax

11. BIRTHPLACE (County & State, or foreign country): Floyd, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William E. Wimmer

14. MOTHER'S MAIDEN NAME: Cora Elizabeth Walton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 213-01-9901

17. INFORMANT: Steven P. Wimmer — Address: Jarrettsville, Md. 21084

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastrointestinal Hemorrhage
DUE TO (b): Massive Laenec's Cirhosis of Live
DUE TO (c): Malnutrition + alcohol
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 581.1
INTERVAL BETWEEN ONSET AND DEATH: Months / 6 months / ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiac decompensation-H.C.V.D + Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/13, 1967, to 12-16, 1967, that (I) (we) last saw the deceased alive on 12/16 1967, and that death occurred at 1:30 P M, from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 12/16/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D. — 22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 12/19/1967 — 23c. NAME OF CEMETERY OR CREMATORY: Bethel — 23d. LOCATION (City or Town) (County) (State): Madonna, Harford, Md.

24. FUNERAL DIRECTOR: Charles E. Kurtz — ADDRESS: Jarrettsville, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 20 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Yeager

21084